The hospital doctor of today – still continuously on duty

BACKGROUND Norwegian hospital doctors emphasise the value of working hard and efficiently and of a high degree of attendance in the workplace. This helps establish social norms that guide behaviour within the professional culture. It is important to examine what consequences these values may entail when the doctor also needs to cater to his or her own needs.

MATERIAL AND METHOD We conducted eight focus-group interviews and three individual interviews among a total of 48 senior consultants and specialty registrars working in the areas of surgery, psychiatry and internal medicine. Total N = 48; 56 % women. The interviews were analysed with the aid of systematic text condensation.

RESULTS When Norwegian hospital doctors wish to appear as good doctors, they see that this entails consequences for the interrelationships with colleagues, the management and the work-life balance. Conflicts of interest arose between senior consultants and specialty registrars. Management initiatives to deal with absence, adaptation of the job to the life stage of each individual doctor and increased management involvement among doctors were among the measures proposed.

INTERPRETATION Better mutual knowledge between doctors and management with regard to each other's values and responsibilities could constitute key premises for structural changes, for example in terms of better planning of leaves of absence and opportunities for adaptation of work schedules to the life stage of the persons concerned.

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MAIN MESSAGE

It may seem as though absence from work threatens the ideal of the perseverance and work capacity of the professionally dedicated doctor.

Many hospital doctors expressed an ambivalent attitude to the relationship between being a leader and being led.

The view of the medical profession as a lifestyle as opposed to a job gave rise to conflicts of interests between young and older hospital doctors.

The traditional notion of the degree of dedication necessary to become a «good doctor» is unclear.

The doctors claim that in order to learn, practise and update themselves in their profession, theoretically as well as in terms of the craft, willingness with regard to a high degree of attendance in the workplace and high work capacity are required (1). In a previous article we have referred to this as «professional dedication» (1). This demonstration of professional dedication on the part of the doctors and their adaptation to the job may entail consequences for other areas of their lives. Numerous studies have pointed to the challenges of establishing a good work-life balance (2), while doctors are less often absent due to illness than others with the same educational background and the same diagnoses (3, 4). The strong collegial solidarity in the medical profession's culture (5) may render doctors more resistant to stress (6) and increase their job satisfaction (7). However, the wish to belong to the «doctors' guild» may also put pressure on doctors to conform to prevailing peer norms (8). For example, it is regarded as unprofessional conduct for doctors to criticise each other (5). We have few descriptions of how the professional culture among doctors influences these conditions (9).

The media frequently highlight the relationship between hospital management and doctors (10), and the distance between these parties is frequently portrayed as significant. Dedication to the profession may be one of the reasons why doctors often feel a stronger affiliation to their discipline than to their organisation (11), and this may render it difficult for hospital managers to lead doctors (12). On the other hand, management and administration are part of the working day for virtually all doctors, and approximately 60 % of all management positions in Norwegian hospitals are occupied by doctors (13). Traditionally, management as a discipline has been given little emphasis in the training of doctors in Norway (14), and the strong position doctors hold in terms of clinical work may contrast with their powerlessness when it comes to administrative tasks (15). It is therefore important to take a closer look at the way in which the doctors feel that this affects their exercise of the profession.

In this article we will investigate the consequences that Norwegian hospital doctors perceive as resulting from «professional dedication», in the workplace and in terms of their work-life balance.

Material and method

Data were collected in the period 2010–2012 through eight focus-group interviews and three individual interviews with a total of 48 hospital doctors, whose medical experience ranged from 5 to 45 years. Altogether 22 of them were specialty registrars and 26 were senior consultants, in psychiatry (n = 19; 58 % women), internal medicine (n = 15; 40 % women) and surgery (n = 14; 71 % women).

We informed about the study through union representatives, managers or those responsible for the doctors' meetings. We recruited a strategic sample of senior consultants and specialty registrars in one large and one small hospital. In medicine and surgery we interviewed groups of senior consultants and specialty registrars respectively, and since it turned out to be difficult to convene busy hospital doctors to group interviews, we conducted three individual interviews with participants who were unable to attend the focus groups. Two group interviews with psychiatrists were conducted at an internal meeting of doctors and included senior consultants as well as specialty registrars. The interviews lasted 1–1.5 hours and were led by a moderator and one or two assistants (Tuva Kolstad Hertzberg, Karin Isaksson Rø and Olaf Gjerløw Aasland). By way of introduction, the moderator opened the conversation with: «How can we achieve an appropriate work-life balance as hospital doctors?» – including consequences and proposals for measures.

The method of analysis used was systematic text condensation, based on Giorgio and developed and modified by Malterud (16). Two of the interviews were coded into categories by Tuva Kolstad Hertzberg and Karin Isaksson Rø, who subsequently discussed their coding with Helge Skirbekk. Tuva Kolstad Hertzberg subsequently coded the remaining interviews accordingly. In a previous analysis of the material we have reported the doctors' descriptions of how they wish to be, and to appear as, a good doctor (1). There we could see that this entailed significant consequences for their everyday life. To investigate these consequences, the data were submitted to a renewed analysis using this as a general topic. Finally we re-contextualised the results in light of the data to reveal similarities that would corroborate our findings and dissimilarities that would refute them (17). The dimensions that defined the general topic are presented in the conclusions section as textual summaries with some quotations for illustration. The participants were offered an opportunity to read through the results section to approve the quotations.

Four of the authors are doctors with a background in psychiatry/occupational medicine and research on the health, work and quality of life of doctors. One of the authors is a sociologist with a research focus on issues of communication and trust in the health services. Each author's awareness of and interest in the topic, personal experience and/or experience from clinical work with doctors who have sought counselling or treatment may have had an impact on our preconceptions about the types of challenges that we might discover. Because the group of authors also represents doctors, clinicians as well as researchers at various stages of their careers, and a sociologist, we have been able to recognise various aspects of the topic and thus to approach the material from multiple perspectives.

The study was approved by the Regional Committee on Medical and Health Research Ethics.

Results

Based on the textual analysis, the consequences of a desire to be an available, professionally dedicated doctor having a high work capacity could be placed along three dimensions: the relationship to medical colleagues, leading and being led, and the work-life balance. Some proposals for measures were also discussed. Few differences emerged in terms of gender, specialties and hospitals with regard to these dimensions.

The collegial community

Because attendance at work and a high work capacity were deemed important characteristics of a good doctor, the absence of individual doctors was frequently portrayed and perceived as a manifestation of inadequate loyalty to colleagues. This may be seen in light of the extra workload the colleagues needed to undertake on such occasions. Many of the senior consultants highlighted the rarity of their own absence – one claimed not to have been absent from work for 35 years. Most of the doctors interviewed believed that absence due to illness was mostly related to how the individual doctors coped with being ill. According to some specialty registrars, this depended on the strength or willingness of each individual doctor to pull him- or herself together and go to work in spite of illness. Absence from weekend duty required an especially good reason. One specialty registrar said that:

«Here, it's the case that what is required to be considered ill may vary somewhat. If I'm on weekend duty, holiday duty or such, well, then in practice I'm not ill.» (Group 8)

Many specialty registrars told us that in a doctor's work «(one) cannot be ill». The consequences of absence of a colleague were more hectic days and less time for professional development for those who were left at work, in addition to unstaffed shifts, which meant shorter rest periods. Absent specialty registrars gave rise to additional work and unpredictability also for the senior consultants who held operational responsibility. Specialty registrars and senior consultants agreed that the marginal staffing situation in hospitals rendered the departments highly vulnerable to absence. The expectations regarding non-absence meant that some specialty registrars dared not share any personal challenges with their colleagues. One senior consultant referred to reports about personal needs as «whining». Doctors who were absent, but deemed by their colleagues not to be sufficiently ill, risked being frowned upon and perceived as lacking dedication and stamina. Absence due to training courses or other professionally related activities, on the other hand, was deemed acceptable. Many specialty registrars perceived that taking breaks or having lunch was deemed unacceptable, and they internalised this to such an extent as to disregard fundamental needs:

«... there is an agglomeration of people who forget to eat and to pee, it's a pressure. When you see and are surrounded by such colleagues, then you're part of it. You're either a part of it, or you're excluded.» (Group 7)

Leading and being led

Many senior consultants who were in managerial positions reported combining leadership tasks with clinical work so as not to lose contact with the profession, but also because they felt that medicine was what they saw themselves as trained to do, rather than management. Many of them stated that they did not want to assume management positions, but that they felt obligated to do so. There was a widespread notion that managers with broad clinical expertise and experience were likely to enjoy trust and legitimacy among their colleagues, but this dual role consumed a lot of time and capacity for those concerned. One senior consultant described his managerial job as an identity crisis:

«... I felt that I had a kind of identity disorder almost, sort of an identity crisis. Although in terms of workload I am just as busy as a clinician and doctor now as I was then (as a manager), it's in a different way. Now I'm doing what I always wanted to do, and what I'm trained for.» (Group 2)

Those doctors who worked as managers were referred to by many as «one of them», i.e. the management, because they did not focus exclusively on medical issues. When the doctors in the study referred to «the management», it was often unclear what level of management they had in mind. There were many, including senior consultants, who felt powerless in the face of the lack of recognition of their competence and effort on the part of the management, and many were of the opinion that the management should plead the doctors' cause to a greater extent. They saw the management as more preoccupied with systems than with people, and claimed that the management let finances and concerns for production decide to an excessive extent.

Both the senior consultants and the specialty registrars described their administrative tasks as matters that were additional to and often competed with their clinical work. There were nevertheless some who claimed that there were too few doctors in administrative positions, and that this may challenge the discipline as well as the future role of doctors.

The work-life balance

Most of the doctors were satisfied to be doctors, but felt that it was a challenge to combine the job with leisure activities and family life. One senior consultant said:

«I'm not counted on at home, and they are very fed up with me never coming home. (...) «There's no point in cooking supper for the entire family, because mum (the doctor) doesn't come home anyway». So they have adapted to this, and they don't wait for me any longer.» (Group 6)

In order to cope with the combination of the job as a dedicated hospital doctor, an active physical exercise schedule – many perceived this as required to cope with stress – and a fulfilling family life, the senior consultants and specialty registrars alike reported that they were completely dependent on support from their partner and/or parents. Many of the senior consultants, for their part, stated that during their period as parents of small children the same allowances had not been made for their situation at home as those enjoyed by specialty registrars today:

«When I was a novice assistant registrar we were told by the senior consultant that in his time, during his internship, they worked split shifts and wrote on a regular typewriter. Being at home with a sick child was thus quite a tough proposition, really.» (Group 2)

As regards the norm of attendance and the challenges involved in the work-life balance, there was a clearer distinction between the senior consultants and the specialty registrars than between the genders. Many of the senior consultants had partners who assumed a lot of the responsibility at home, while the specialty registrars needed to assume a larger share of this responsibility themselves. Both male and female specialty registrars expressed a desire to attempt to balance their job as a doctor with leisure time and family life. Some described how their choice of specialty was influenced by the amenability of this specialty to an appropriate work-life balance. Some senior consultants were of the opinion that specialty registrars were mostly concerned with their responsibilities outside of work, by staying home with sick children or leaving work early to pick children up from day-care, leaving them with the responsibility for getting the job done. The specialty registrars, on the other hand, felt constrained in taking care of their home situation because they were apprehensive about not being perceived as sufficiently dedicated.

What can be done?

There was a broad consensus that better planning on the part of the management might make the work situation more predictable and less stressful. Many, specialty registrars and senior consultants alike, were of the opinion that allowances for some absence ought to be made in the work schedule:

«Well, and then the supply of resources or the development has lagged behind, so in terms of staffing we are still in a situation where nobody is expected to be ill, nobody has sick children and we can work some ten to twelve hours of overtime every week.» (Group 2)

In one hospital, an attempt to compensate for absence was made by imposing mandatory attendance on the specialty registrars on their study days, and PhD candidates had to come in as locums to perform clinical work during their research time.

Some came up with the idea of a «life stage-dependent facilitation» that could improve working conditions and reinforce patient safety. A number of senior consultants proposed better facilitation on the part of the management to induce doctors to accept managerial jobs.

Discussion

We find challenges associated with the ideals of being good hospital doctors in the collegial community, in terms of leading and being led, and in the work-life balance. Norwegian and international studies show that many doctors go to work even though they are ill, and they expect their colleagues to do the same (18). On the one hand, this is a matter of loyalty; they do not wish to burden their colleagues with extra work. On the other hand, absence may be a threat to the ideal of the professionally dedicated doctor's stamina and work capacity. One example of this is when younger colleagues prioritise other aspects of life and thereby challenge the attitudes of their older colleagues regarding the degree of dedication required of a «good doctor». The clarity with which the senior consultants emphasised that the professional culture should not be open to whiners was a factor when some specialty registrars failed to report the challenges they encountered in achieving the expected degree of attendance. Because many specialty registrars experience challenges in living up to the norms of the collegial community, and for as long as the degree of professionalism at least in part appears to be measured in terms of the number of hours worked, this generational gap between doctors will persist (9). Such internal conflicts among doctors may cause challenges to be individualised, because they are hard to structure at an organisational level.

Today, both male and female doctors tend to have partners who have careers of their own, and the partner will often also be a doctor (19). This notwithstanding, the professional culture appears to maintain the notion that showing consideration for the family is irreconcilable with being a «good doctor». This is consistent with the findings from a study undertaken among general practitioners, for whom appearing healthy was important, because they felt that their state of health was used as an indicator of their medical competence (20). Given that social support from colleagues has been shown to enhance well-being (21), disassociating from this type of notion is especially difficult.

One obvious way to reduce stress associated with the work-life balance is to reduce working hours (19), but in Norway as well as internationally it is being debated whether a further reduction of doctors' working hours may lower the level of specialist training (22). Moreover, the quality of health services may be linked to the doctors' well-being (23), although this has not been widely studied in Norwegian hospitals.

This study has shown that the norms of attendance and work capacity challenge concerns for personal matters, but also help maintain full staffing at work. When absence is dealt with internally among colleagues, it is unlikely that much of this information will ever reach the management. For managers to be able to facilitate opportunities for absence, they require to know about needs. There is a discrepancy between the large degree of independence and self-management enjoyed by doctors and their concurrent expectation that the management should observe and cater to their needs. This may give rise to uncertainty and lack of involvement on the part of the management in matters such as dealing with absence. A Swedish study has shown that hospital managers often apply a weak, indistinct and partly absent management style vis-a-vis doctors (12). It is questionable whether Norwegian hospital managers enjoy sufficient trust and recognition from the medical collegium to succeed in their management of doctors.

Doctors working in Norwegian hospitals have clinical as well as organisational responsibilities. The combination of the doctors' insufficient training and experience in management (24) and the fact that the legitimacy of a manager in charge of doctors depends on recent clinical experience may

render leadership positions quite challenging and reduce their attractiveness in the eyes of doctors. This contrasts with the situation for nurses, who gain in status through accepting administrative and management positions (25). In addition, many doctors claim that it is crucial for colleagues to accept management positions to contribute professional competence and to have a say in the design of the doctor's role in the health services of the future.

There is a clear need for more recognition, in the medical collegium as well as by hospital management, of the fact that doctors also are entitled to be absent when they or their children are ill. This will be a challenge to hospital staffing plans. Clearer leadership, combined with better mutual understanding, may help facilitate structural changes that would benefit the doctors' working situation as well as quality and safety in their work with patients.

As a methodological comment, we would like to add that the strength of a qualitative study is its ability to generate experience-based knowledge, more than quantitative rankings (26). The external validity of the study's findings is nevertheless maintained by the inclusion in the material of doctors from a large, centrally located hospital and a small, local hospital, from a diversity of disciplines, and specialty registrars as well as senior consultants (26).

The recruitment may have resulted in a sample of doctors who have a particular interest in the topic and better opportunities to work long hours, because the interviews were largely conducted at the end of the working day. In focus groups, the participants may influence each other, thus producing a larger consensus effect than might perhaps have been obtained by individual interviews (26). The fact that the moderators were doctors may on the one hand have helped promote understanding and recognition of the matters described, but on the other may also entail a risk that certain factors specific to doctors might have been taken for granted and not explicitly mentioned.

During the analysis we have looked for variations around the main topics in order to reinforce the internal validity of the findings. The findings have also been presented and discussed in various clinical and research fora, and the participants have been provided with an opportunity to read through the results and approve the use of quotations. The results of the study indicate some possible implications and proposals for measures for which various stakeholders may assume responsibility. The Norwegian Medical Association could promote a discussion on the balance between professional dedication and consideration of personal needs as a topic in various specialist training programmes and managerial training courses, to make this a natural part of identity development as a doctor. In addition to the advisory services available to individual doctors through the peer counselling scheme (27) and Villa Sana (28) it is crucial to enable doctors to cater better to their own needs at an individual and collegial level.

The hospital doctors themselves may help establish a wider space for voicing reflections in the collegium on the challenges inherent in being a good doctor while also catering to personal needs. Acceptance among colleagues and better mutual knowledge between doctors and managers regarding the values and responsibilities of the other party will represent key premises for undertaking structural changes, such as life-stage adaptation of the hospital doctor's job. To achieve change, it will be crucial that those responsible for organisation of the health services at various levels help facilitate and enable such processes as have been described above.

Conclusion

Expectations of professional dedication, combined with governing norms about attendance, perseverance and hard work, entail consequences for the medical collegium, for the relationship to the management and handling of the work-life balance.

The study shows that it is crucial for the profession to reflect on what might be good enough, because such a norm will be necessary for doctors to cater adequately to their own needs. However, achieving this will be a complex and difficult balancing act, because the needs are conflicting. How this balance should be dealt with at the group and individual levels is a question that merits discussion.

We wish to thank the doctors who participated in the interviews and helped us with the information meetings and facilitation at the initial stage of the study.

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Received 20 January 2016, first revision submitted 22 May 2016, accepted 12 August 2016. Editor: Tor Rosness.